DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

Office of Public Health Preparedness and Response (OPHPR)
Board of Scientific Counselors (BSC)

Summary Report
April 26, 2010 Web Conference

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Web Conference Agenda
Board of Scientific Counselors (BSC)
Office of Public Health Preparedness and Response (OPHPR)
Centers for Disease Control and Prevention (CDC)

Monday, April 26, 2010
1:30 pm – 4:00 pm (EDT)

Roybal Campus, Global Communications Center (GCC), Building 19, Auditorium B3

1:30 – 1:40 p.m.	**Welcome and Introductions** Barbara Ellis, Ph.D., Acting Associate Director for Science, OPHPR Designated Federal Official
1:40 – 1:45 p.m.	**Introductory Remarks** Dan Sosin, MD, MPH, FACP, Acting Director, OPHPR
1:45 – 1:50 p.m.	**Review of FACA Conflict of Interest Issues** Barbara Ellis, Ph.D., Acting Associate Director for Science, OPHPR Designated Federal Official
1:50 – 2:25 p.m.	**Report to BSC on External Peer Review of Division of State and Local Readiness** Dr. Ellen MacKenzie, BSC Member; Co-Chair, DSLR Workgroup
2:25 – 2:50 p.m.	**Discussion and Recommendations** Dr. Ellen MacKenzie, BSC Member; Co-Chair, DSLR Workgroup
2:50 – 3:00 p.m.	**Comments from Liaison Representatives**
3:00 – 3:10 p.m.	**Public Comment Period**
3:10 – 3:30 p.m.	**Vote on Recommendations** Barbara Ellis, Ph.D., Acting Associate Director for Science, OPHPR Designated Federal Official
3:30 – 4:00 p.m.	**Updates from Liaison Representatives** (5 min each) • Association of Public Health Laboratories (APHL) • Association of Schools of Public Health (ASPH) • Association of State and Territorial Health Officials (ASTHO) • Council of State and Territorial Epidemiologists (CSTE) • National Association of County & City Health Officials (NACCHO) • National Indian Health Board (NIHB)
4:00 p.m.	**Adjourn** Barbara Ellis, Ph.D., Acting Associate Director for Science, OPHPR Designated Federal Official

Monday, April 26, 2010

Welcome and Introductions

Barbara Ellis, Ph.D., Designated Federal Official
Acting Associate Director for Science, Office of Public Health Preparedness and Response

Dr. Ellis called the meeting to order and welcomed everyone to the web conference. Introductions for individuals in the meeting room were conducted. Dr. Ellis explained the purpose of the meeting was to deliberate and vote on recommendations from the external peer review of OPHPR's Division of State and Local Readiness (DSLR). Dr. Ellis then led a role call for those participating by phone. She emphasized that it was critical that the voting members remain on the call to participate in the voting period for this meeting. If anyone needed to leave earlier, they were asked to communicate that need immediately so that a quorum determination could be made. Dr. Robert Ursano indicated a need to leave the call temporarily between 2:30 to 3:00 PM; therefore Dr. Ellis advised that voting would begin at 3:00 PM.

Liaison representatives participating on the phone were asked to introduce themselves. Dr. Ellis indicated that Mary Shaffran was representing the Association for Public Health Laboratories for Dr. Mary Gilchrist. Phone lines were opened for any other public participants who were joining to introduce themselves.

Dr. Ellis explained that the discussions for this meeting would be led by the co-chairs of the BSC workgroup, BSC members, and Ex Officio members. Liaison representatives will be invited to comment following the BSC discussions. All other remote participants would be placed on a listen-only line and invited to speak during the public comment period. Speakers were advised to identify themselves by name each time for the meeting record. Remote participants were advised to mute lines to minimize background noise when not speaking.

Dr. Ellis then introduced Dr. Sosin to provide some additional introductory remarks.

Introductory Remarks from OPHPR Acting Director

Dan Sosin, M.D., M.P.H.
Acting Director, Office of Public Health Preparedness and Response

Dr. Sosin personally thanked everyone present on behalf of the Office of Public Health Preparedness and Response for taking time to make their expertise available for the benefit of not only OPHPR, but also for CDC, and the nation. He thanked everyone for their participation to ensure that OPHPR programs do the job that they are supposed to, which is to provide a national strategy that works.

Dr. Sosin welcomed a newly appointed representative from the National Indian Health Board, Stacy Bohlen. Stacy was unable to make today's web conference and so the NIHB was being represented by Rick Haverkate and he welcomed Rick for being present.

Dr. Sosin noted that there have been some organizational improvement changes at CDC and OPHPR that many present were aware of. One such change was the incorporation of the Emergency Risk Communication Branch which has been integrated into the emergency management structure. Also, the Biosurveillance Coordination Unit was moved to CDC's Office of Surveillance, Epidemiology and Laboratory Services (OSELS) and the Emergency Risk Communications Group has been moved to OPHPR's Division of Emergency Operations (DEO). There have been a number of changes in legislative, advocacy, and advisory bodies.

Dr. Sosin noted that for now he is the Acting Director for OPHPR, but that a permanent OPHPR Director is currently being recruited.

For this meeting, Dr. Sosin indicated that the group would be deliberating and voting on a BSC ad hoc workgroup's recommendations on DSLR's proposed strategy for prioritization of capabilities for the Public Health Emergency Preparedness (PHEP) grantees as well as a change management process for changes to the PHEP cooperative agreement guidance. He personally thanked Drs. Harrald and MacKenzie for co-chairing this review and for traveling to Atlanta to attend this meeting in person. He expressed appreciation for everyone's patience in helping OPHPR to move forward on at least one of its external peer reviews as this was the only mechanism that this group could realistically use to obtain a quorum for this meeting. He also noted that the nomination package to replace retired BSC members is with HHS for approval.

Since the BSC ad hoc workgroup meeting was held, the National Health Security Strategy has been updated and an accompanying *Interim Implementation Guide* has been published. The first *Implementation Plan* is scheduled for release in September 2010. The recommendations provided from this review will impact the guidance that DSLR publishes next year for their next funding cycle.

Dr. Sosin then turned the meeting back over to Dr. Ellis to review FACA conflict of interest issues.

Review of FACA Conflict of Interest Issues

Barbara Ellis, Ph.D., Designated Federal Official
Acting Associate Director for Science, Office of Public Health Preparedness and Response

Dr. Ellis reiterated Dr. Sosin's thanks to the Board for their service to the federal government by participating on this advisory committee. The goal of the Board's efforts is to help create and support a transparent, multi-disciplinary process for external expert review and improve OPHPR's capacity to continuously improve processes, programs, and vision through their input. Dr. Ellis also thanked everyone for participating in these external program reviews as they are substantial work for the reviewers and the programs.

Dr. Ellis reviewed the description of duties of the BSC from the committee charter:
The Board shall provide advice and guidance to the Secretary, Department of Health and Human Services; the Assistant Secretary for Health; the Director, Centers for Disease Control and Prevention; and to the Director, OPHPR, concerning strategies and goals for the programs

and research within the divisions; will administer and oversee peer-review of OPHPR scientific programs; and monitor the overall strategic direction and focus of the divisions and offices. The Board, after administering and overseeing the peer reviews, shall submit an annual summary of the results of the reviews and recommendations to the Associate Director for Science and the Director, CDC.

With regard to disclosure, the goal in appointing members to our Board is to achieve the greatest level of expertise, while minimizing the potential for actual or perceived conflicts of interest. For certain interests that potentially enhance the Board members' expertise while serving on the committee, CDC has issued limited conflict of interest waivers. Members with conflicts of interest may serve as consultants to present to the Board on certain matters; however, they are prohibited from participating in deliberations or committee votes on these matters.

Dr. Ellis then asked if there were any Board members that would like to identify a conflict of interest at this time. No conflicts of interest were declared.

Report to BSC on External Peer Review of Division of State and Local Readiness (DSLR)

Ellen MacKenzie, Ph.D.
BSC Member, Co-Chair, DSLR Ad Hoc Workgroup

Dr. MacKenzie expressed hers and Dr. Harrald's pleasure to be with the group to go over the findings from this review. Dr. Harrald will be presenting the first half of the recommendations pertaining to the prioritization process, and she will present the change management recommendations.

Jack Harrald, Ph.D.
BSC Member, Co-Chair, DSLR Ad Hoc Workgroup

Dr. Harrald noted that the objectives of the external peer review were to:

- Evaluate and provide recommendations to the DSLR's process to select Public Health Emergency Preparedness (PHEP) cooperative agreement priority capabilities in context of existing priorities (legislative, departmental, and agency mandates, available funding, CDC preparedness goals and the mission, needs, and goals of OPHPR).
- Evaluate and provide recommendations to DSLR's proposed approach to coordinate, organize, and manage the various CDC, HHS, and partner stakeholders' input in the development and management of future content for the PHEP Program Announcement.

The workgroup members that participated in this process were:

BSC Workgroup Members

NAME	AFFILIATION	DISCIPLINE / EXPERTISE
Jack Harrald, Ph.D. *Workgroup Co-Chair*	**Virginia Tech**	**Engineering**
Ellen MacKenzie, Ph.D. *Workgroup Co-Chair*	**Johns Hopkins University School of Public Health**	**Behavioral Science**
Harry Hatry, M.S.	**The Urban Institute**	**Project Management**
Ricardo Millett, M.P.P., Ph.D.	**Millett & Associates**	**Grants Management**
Patrick Libbey	**Former NACCHO Executive Director**	**Public Health Practice**
Bonnie Arquilla, D.O.	**State University of New York (SUNY) Downstate**	**Emergency Preparedness**

Dr. Harrald recognized that there was significant input from DSLR and this review required a momentous amount of work. He then summarized the review process timeline which consisted of (1) a pre-meeting webinar held on August 31, 2009 to discuss background materials provided to the reviewers on the history of DSLR and PHEP priorities, the proposed prioritization process, and the proposed change management board, (2), the workgroup meeting held on September 15-17, 2009 which included presentations from DSLR and stakeholders, question-and-answer sessions, workgroup deliberation, and writing of the draft report, and (3) post-meeting activities including a meeting of the full Board on April 26, 2010 to vote and deliberate on final recommendations to DSLR and OPHPR leadership, a formal response to the BSC recommendations from DSLR in August 2010, and an update from DSLR on implementation of the recommendations in August 2011 and annually thereafter.

The PHEP Cooperative Agreement is intended to fund state and local efforts to build and strengthen preparedness and infrastructure to respond to all hazards. It has a history of being strongly influenced by legislative mandates and significant oversight by the HHS. There have been annual shifts in the number and type of recommended activities, depending on interests of various stakeholders. In 2004, program priorities were more focused on achievement of targeted capabilities and all-hazard preparedness. The recommendations from this review are intended to inform the new PHEP Program Announcement in FY2011.

Dr. Harrald noted that a significant accomplishment in the workgroup's view was to base the cooperative agreement on major accomplishments, but with an attempt to prioritize capabilities based on the strength of legislative and executive mandates using a top down approach. He noted however that this approach does not encourage local and regional flexibility based on differences in vulnerabilities, needs, strategy, and existing capabilities and capacities. The proposed prioritization process methodology was based on an inherently subjective system of assigning priorities based upon:

- Perceived strength of match of the capability to policy and other documents [e.g., Pandemic All Hazards Preparedness Act, Homeland Security Presidential Directive

(HSPD)-5, HSPD-8, HSPD-21, National Association of County and City Health Officials (NACCHO) Project Public Health Ready], and
- Relative importance of the policy documents to the PHEP based on type (e.g., public law, Presidential Directive, other).

Dr. Harrald further noted that ideally the prioritization process should be outcome- and evidenced-based, wherever possible. The workgroup felt that DSLR should elicit external expert judgment through, for example, a multi-attribute utility analysis or analytic hierarchy process. In addition, efforts to establish goals and metrics for target capabilities will enhance DSLR's ability to manage the PHEP and enhance national preparedness if established and monitored collaboratively with their awardees.

The workgroup's individual recommendations for the prioritization process were as follows:

1. PHEP funding should be based on the 20 targeted capabilities identified as having central public health relevance. However, all 37 targeted capabilities should be listed in the Cooperative Agreement for informational purposes to preserve the continuum of overall community preparedness. The public health capacity created by funding the 20 public health related targeted capabilities may support one or more of the remaining 17 capabilities.

2. The short form of the Targeted Capabilities List (TCL) should be provided as an appendix to the Cooperative Agreement. The DSLR should be prepared to provide interpretation and clarification of the targeted capabilities.

3. The 20 public health related targeted capabilities should not be divided into three prioritized tiers or rank-ordered at least not until strong evidence is available to support the establishment of priorities.

4. CDC/DSLR efforts to define a limited number of performance and outcome measures for each of the public health related targeted capabilities should be continued. Special priority should be given to developing a comprehensive set of metrics for assessing the outcomes from exercises, drills, and actual emergency incidents. The measures should be consistent and useful across federal, state and local levels. These measures will provide the basis for establishing an evidence-based prioritization of public health preparedness goals. Consistent reporting of these measures should be required as a condition of continued PHEP funding.

5. The Cooperative Agreement should require that a hazards vulnerability and gap analysis be completed in Year 1. These analyses should drive the development of a five-year strategic plan that addresses how the awardees will attend to the 20 public health related targeted capabilities. These analyses should be viewed as living documents, updated as needed to maintain currency, and used to support future funding needs. Technical assistance and guidance documents should be available to awardees to help them with these tasks.

6. Guidance materials should be provided by CDC. These materials should include standards for performing and reporting the results of the hazards vulnerability assessments and gap analysis.

Dr. Harrald then turned the meeting back over to Dr. MacKenzie to share the workgroup's findings for the change management process.

Ellen MacKenzie, Ph.D.
BSC Member, Co-Chair, DSLR Ad Hoc Workgroup

Dr. MacKenzie noted that the workgroup was also asked to look at the need to have a more transparent change management process. There has been a history of requests for changes to the PHEP requirements, so it was recommended that a Change Management Board (CMB) be created. The workgroup was very much in favor of this and was convinced that it was not only necessary but a positive thing to do. A CMB should bring stability to PHEP operations and address awardees' confusion over shifting priorities and activities. It would reduce the possibility that changes would be introduced into PHEP without full consideration of the impact on all stakeholders. The workgroup agreed with the 'Critical Success Factors' outlined in DSLR's proposal. The workgroup felt that it was important that all stakeholders at the highest level of their respective agencies conform to the change management process, that safeguards are put in place to prevent "end-runs" around the CMB, and that transparency is critically important. She further noted that the criteria for determining the significance of the change must be clearly understood and accepted by all requestors.

The workgroup further agreed that change requests must clearly address awardees' capacity to perform the requested change and the resources required to implement. Change requests must address and provide a solution for DSLR staffing support to implement the proposed new priority. Precautions must be in place to ensure the change management process is nimble enough to be responsive to real needs in a timely manner without becoming a major planning body itself. The process may stifle motivation to propose changes given a strict process for submitting, assessing, reviewing, and approving. Ongoing monitoring is critical, and a tracking system is needed to ensure requests are handled in effective and efficient manner.

These workgroup findings led to several individual recommendations as follows:

1. The workgroup recommends to the OPHPR Director that in order to help preserve the integrity of the process, the Chair of the Change Management Board should directly report to the Director of CDC.

2. Explicit criteria should be developed to assist in categorizing a proposed change as an administrative revision or update not requiring full review by the CMB.

3. Explicit criteria should be developed for review of all proposed change requests brought to the CMB. These criteria should include: consideration of the cost and burden of a proposed change on awardees; the impact of the proposed change on currently funded programs; and the overall feasibility of implementation, including technical and timeliness considerations. Both short and long-term effects should be considered.

4. Requests must be forwarded to NACCHO and ASTHO for their comments on the request and its potential impact on awardees. These comments should be routinely included in the materials made available for review by the CMB.

5. To ensure timely and consistent review, careful consideration should be given to the frequency of the scheduled meetings of the CMB. Meetings should be frequent enough to prevent backlogs and unnecessary emergency meetings and assure that requests are not put on hold for an extended period of time.

6. All change requests should be resolved within a reasonable, pre-defined time limit.

7. An appeal process should be defined to preserve the integrity of the process.

8. A Program Change Request Tracking System should be designed and implemented. This could considerably ease the manual tracking of change requests, provide a considerably more efficient process, and provide a clear record of events. The system would automatically undertake such activities as: (a) identify who needs to review each category of request (such as whether emergency or not, changes relating to particular hazards, those that are purely administrative change requests, etc.; (b) track the status of those reviews and needed sign offs for each category of request; (c) keep track of the time periods and give warnings for behind schedule reviews; and (d) summarize overall progress of the changes for the year. CDC would likely need to assign a staff member to be the Program Change Administrator, if only part time.

9. After 1 year of implementation, the process should be internally reviewed and changes made accordingly.

Discussion and Recommendations

Dr. MacKenzie then opened the discussion for the BSC members' comments and questions. Members were asked to identify themselves before speaking.

Sharona Hoffman commented that this is an excellent report. On the first recommendation, how realistic is it that there will be actual oversight? What if the director is too busy to do oversight?

Dr. Harrald commented that this point is well taken – if all oversight is given to the director.

Dr. Sosin responded that he wanted to convey that his concern is not that it goes to the director, but the context of justification for going to the top. But it may be a challenge. The director may delegate those responsibilities, but the intent is for the director to see issues that are coming up from this process.

Dr. Harrald added that issues would be going to upper level to preserve the integrity of the process.

Sharona Hoffman commented that she would like to see some language that tightens that up. Sometimes when you delegate too high up, it falls through the cracks because no one is actually seeing to it that the issue actually gets handled. We might actually want to introduce some language that says that the CDC director may delegate to a particular individual so it is not left hanging out there. It's the CDC director or nothing.

Dr. Sosin pointed out that since the deliberation of the workgroup, the CDC organizational structure has changed as well. We do now have a Deputy Director within the Office for State, Tribal, Local and Territorial Support (OSTLTS), Dr. Judith Monroe. I noticed there's a lot of importance on the process being protected. Dr. Monroe may be less partial about the day-to-day management and could assure that issues are elevated outside of OPHPR.

Dr. Harrald commented that he felt that it would make sense to move that that be added. Sharona Hoffman made a motion to make that change to the recommendations and Jack Muckstadt seconded the motion.

Louis Rowitz asked for clarification in that by selecting as an alternative the director of another office to be the chair, what becomes of the relationship between OPHPR and that office.

Dr. Sosin commented that this is a work in progress. He added that what you see in a change management process is a system of checks and balances. Having the chair reside outside OPHPR could introduce an independent third party. At the end, the CDC Director would have the final authority. We would still need to see if the Deputy Director for OSTLTS would want to accept. We can report back to the Board with what is feasible to execute.

Dr. Harrald noted that he felt the Board had a valid agreement and recommended that the Board adopt this change to the recommendation as discussed.

Dr. MacKenzie agreed and asked for comments from the liaison representatives.

Comments from Liaison Representatives

Dr. Jim Curran from the Association of Schools of Public Health (ASPH) commented that he really appreciated the report and he felt that the comment about change might indicate a different relationship with the state and local health department. He added that it might help him to think that in terms of what went wrong in the past might go right in the future.

Christa Singleton from DSLR added that if we heard you correctly, you would like to see this in an example like around H1N1 and how it might be applied in this process. We did our guidance around H1N1 funding and made changes throughout those first 6 months. This process would need an expedited process. The change management board would have to quickly convene and make adjustments as necessarily. It would not be a monthly board meeting, which is what we were concerned about.

Dr. Harrald commented that there should also be a sorting process for those that go immediately into the administrative track. Major programmatic changes should be handled with priority.

Christa Singleton stated that is the intent. If it was a major shift that would rise to the level of a meeting deliberation. Chris Kosmos, DSLR Director, added that it does raise an important point on the authority of the Board. She noted that none of us want to be in the position of running a response through a change management board. Emergency response should be outside the lane of the change management board.

Karen Smith from NACCHO congratulated the group on a couple of things. She noted that she really appreciated the focus on capacities and capabilities rather than outcomes and effectiveness. NACCHO is trying to increase the use of evaluation studies to get more added value from preparedness funds. Also, they will need to figure out how to balance this with what is going to work in individual communities and states. She indicated that it is good to hear that from where we sit.

Mary Mazanec from HHS/ASPR congratulated the workgroup. She commented that she assumed that a charter for CMB membership would be written. She noted that it seems that change management members should consist of Federal persons both within CDC and HHS/ASPR and asked whether the request for change can come from internal, from federal government or stakeholders, or awardees. Dr. Mazanec asked if that was correct.

Dr. MacKenzie responded that was correct.

Public Comment Period

No comments were made by the public.

Vote on Recommendations

Barbara Ellis, Ph.D., Designated Federal Official
Acting Associate Director for Science, Office of Public Health Preparedness and Response

Dr. Ellis called for a vote from the Board on final recommendations for DSLR. The first set of recommendations voted on was that pertaining to the prioritization process:

Prioritization Process Recommendations (1-6):

1. PHEP funding should be based on the 20 targeted capabilities identified as having central public health relevance. However, all 37 targeted capabilities should be listed in the Cooperative Agreement for informational purposes to preserve the continuum of overall community preparedness. The public health capacity created by funding the 20 public health related targeted capabilities may support one or more of the remaining 17 capabilities.
2. The short form of the Targeted Capabilities List (TCL) should be provided as an appendix to the Cooperative Agreement. The DSLR should be prepared to provide interpretation and clarification of the targeted capabilities.
3. The 20 public health related targeted capabilities should not be divided into three prioritized tiers or rank-ordered at least not until strong evidence is available to support the establishment of priorities.
4. CDC/DSLR efforts to define a limited number of performance and outcome measures for each of the public health related targeted capabilities should be continued. Special priority should be given to developing a comprehensive set of metrics for assessing the outcomes from exercises, drills, and actual emergency incidents. The measures should be consistent and useful across federal, state and local levels. These measures will provide the basis for establishing an evidence-based prioritization of public health preparedness goals. Consistent reporting of these measures should be required as a condition of continued PHEP funding.
5. The Cooperative Agreement should require that a hazards vulnerability and gap analysis be completed in Year 1. These analyses should drive the development of a five-year

strategic plan that addresses how the awardees will attend to the 20 public health related targeted capabilities. These analyses should be viewed as living documents, updated as needed to maintain currency, and used to support future funding needs. Technical assistance and guidance documents should be available to awardees to help them with these tasks.

6. Guidance materials should be provided by CDC. These materials should include standards for performing and reporting the results of the hazards vulnerability assessments and gap analysis.

Motion and Vote: Prioritization Process Recommendations (1-6)

Ellen MacKenzie:	Yes
Sharona Hoffman:	Yes
Jack Muckstadt:	Yes
Robert Ursano:	Yes
Louis Rowitz:	Yes
Terry Adirim:	Yes
Amy Kircher:	Yes
Mary Mazanec:	Yes

Discussion:

There was no further discussion.

Dr. Ellis next called for a vote on the second set of recommendations for the change management process:

Change Management Recommendations (7-15):

7. In order to help preserve the integrity of the process, the Chair of the Change Management Board should directly report to the Deputy Director, Office for State, Tribal, Local and Territorial Support.
8. Explicit criteria should be developed to assist in categorizing a proposed change as an administrative revision or update not requiring full review by the CMB.
9. Explicit criteria should be developed for review of all proposed change requests brought to the CMB. These criteria should include: consideration of the cost and burden of a proposed change on awardees; the impact of the proposed change on currently funded programs; and the overall feasibility of implementation, including technical and timeliness considerations. Both short and long-term effects should be considered.
10. Requests must be forwarded to NACCHO and ASTHO for their comments on the request and its potential impact on awardees. These comments should be routinely included in the materials made available for review by the CMB.
11. To ensure timely and consistent review, careful consideration should be given to the frequency of the scheduled meetings of the CMB. Meetings should be frequent enough to prevent backlogs and unnecessary emergency meetings and assure that requests are not put on hold for an extended period of time.
12. All change requests should be resolved within a reasonable, pre-defined time limit.
13. An appeal process should be defined to preserve the integrity of the process.
14. A Program Change Request Tracking System should be designed and implemented. This could considerably ease the manual tracking of change requests, provide a

considerably more efficient process, and provide a clear record of events. The system would automatically undertake such activities as: (a) identify who needs to review each category of request (such as whether emergency or not, changes relating to particular hazards, those that are purely administrative change requests, etc.; (b) track the status of those reviews and needed sign offs for each category of request; (c) keep track of the time periods and give warnings for behind schedule reviews; and (d) summarize overall progress of the changes for the year. CDC would likely need to assign a staff member to be the Program Change Administrator, if only part time.

15. After 1 year of implementation, the process should be internally reviewed and changes made accordingly.

Motion and Vote: Change Management Recommendations (7-15):

Ellen MacKenzie:	Yes
Sharona Hoffman:	Yes
Jack Muckstadt:	Yes
Robert Ursano:	Yes
Louis Rowitz:	Yes
Terry Adirim:	Yes
Amy Kircher:	Yes
Mary Mazanec:	Yes

Discussion:

There was no further discussion.

Dr. Ellis thanked everyone for their participation in the vote. She then opened the floor for liaison representatives to give updates from their respective organizations.

Updates from Liaison Representatives

Mary Shaffran
Association of Public Health Laboratories (APHL)

Ms. Shaffran, representing Mary Gilchrist on behalf of APHL, expressed her appreciation and said that she looked forward to continuing to work with the group in the future. She had no updates other than APHL will have an all-hazards survey issued in a couple of months. APHL would like to put some major messages in that survey.

James Curran
Association of Schools of Public Health (ASPH)

Dr. Curran congratulated the group for their completion of the report. ASPH really appreciated the OPHPR name change and symbolically what it means for CDC's public health readiness. He pointed out the opportunity to get closer to state and local health departments.

Dr Curran shared that ASPH and CDC are working together on developing public health preparedness core competencies. He acknowledged that there has been good representation from CDC, ASTHO, and NACCHO leadership. The competencies developed were released for the first round of stakeholder input and ASPH has received 350 inputs thus far. ASPH will be releasing two more rounds before December. There was an RFA under the PAHPA legislation released last week and ASPH will respond. CDC announced that they anticipated 14 centers to be rewarded. Grants will be reviewed for readiness of capability to work with state and local health departments. He welcomed any suggestions from the Board or others. Dr. Curran expressed a desire to work with CDC to see how the training centers can best meet their needs. ASPH also visited all of the Preparedness and Emergency Response Research Centers (PERRCs) to learn from them.

Damon Arnold
Association of State and Territorial Health Officials (ASTHO)

ASTHO has had several meetings with the council, this past week they met with their Board. The CDC, ASPR, and several associations shared updates to the Homeland Security issues. They are looking at the impact of the new healthcare legislation on stakeholders and trying to figure out how it will impact the states and their relationship with the states. ASTHO would like to commend CDC on this document and hope that this will serve as a guidepost for how CDC will address issues with the states.

ASTHO is also moving forward on state levels with HIT and HIE initiatives. Challenges include making sure that they have enough federal and state money to maintain staffing and training.

Many states are facing inadequate resources and staffing. ASTHO hopes that the recommendations are aligned with the abilities of the state and local health departments to comply with targeted capabilities. Dr. Arnold thanked the group for all their hard work.

Patty Quinlisk
Council of State and Territorial Epidemiologists (CSTE)

Dr. Quinlisk also seconded Dr. Arnold's sentiments and expressed appreciation for the work that was done on these recommendations.

For CSTE, the budget is their biggest challenge right now. The most concern is travel issues and giving approval for travel. Their interactions with CDC and other partners have been limited because of their travel issues. Because of budget issues, states are implementing furloughs for various numbers of days and this has impacted CSTE pretty significantly.

Dr. Quinlisk shared that CSTE is engaged with CDC on laboratory reporting. She pointed out a commitment to have universal electronic laboratory reporting by 2013, which will help to ensure their ability to respond. CSTE will be having a meeting the second week in June in Portland. There is some concern about how the budget will affect attendance.

The response to H1N1 has allowed CSTE to experience a real-life test of its emergency response system. CSTE appreciates the leadership from CDC, particularly in the surveillance area and instructing CSTE on how to initiate new surveillance systems quickly.

Karen Smith
National Association of County & City Health Officials (NACCHO)

Dr. Smith expressed her thanks to the workgroup for its hard work.

She conveyed that H1N1 was NACCHO's biggest preparedness response. The organization has been spending a great deal of time capturing lessons learned at the local level because there are so many different relationships with the private sectors and the response looks different in each sector.

NACCHO also wishes to look at the science of capturing best practices. This was the first time they were involved in a nationwide health response with the H1N1 virus. NACCHO appreciated CDC's help in providing a way for them to get information much more quickly with staffers embedded at CDC, which in turn allowed a quicker turnaround time to state officials. Conversations with colleagues at CDC were very helpful working almost synchronously on many conference calls and added richness to the conversations between NACCHO and local level stakeholders as well.

NACCHO is also looking at evaluation, focusing on measurement with the intent to apply this to evaluating Project Public Health Ready. Epidemiologists play a large role in helping NACCHO to develop measurement data in this process. OMEB in DSLR is piloting surveillance and epidemiologic measures at the local level and we are interested in challenges for local public health.

Dr. Ellis asked if NACCHO will be posting their results on lessons learned.

Dr. Smith replied that they would and that a lot of jurisdictions are doing after-action reports. Some are focusing on vaccination and some on non-vaccination and still others on all of the above. NACCHO hopes to be able to find promising practices and to add those to the toolbox.

Rick Haverkate
National Indian Health Board (NIHB)

Mr. Haverkate who was representing Stacy Bohlen from the National Indian Health Board had left the call earlier so there were no updates shared from the NIHB at this time.

Dr. Barbara Ellis called for any updates from our ex officio members.

Dr. Mary Mazanec representing the Department of Health and Human Services/Assistant Secretary for Preparedness and Response (HHS/ASPR) noted that there is a lot of focus on security and safety issues related to laboratories with select agents. There have been several reports that have come out both from interagency bodies and also various commissions that focus on practices. There is an interagency process on internal security and HHS/ASPR is looking at the recommendations to find ways to optimize our practices in biosecurity. Our national security staff have been involved in countering biological threat issues. HHS/ASPR is also looking at H1N1 issues to evaluate the response – what worked, what did not, what had an impact. CDC is involved in these efforts.

Dr. Terry Adirim representing the Department of Homeland Security (DHS) noted that she has been very involved with FEMA and their children's division on initiatives to infuse the interests of children and families into their hazard preparedness.

Dr. Amy Kircher representing the Department of Defense (DOD) commented that DOD is undergoing some change also. She noted that they have a new position, Assistant Secretary for Health Affairs, to be headed by Jonathan Woodson from Boston. NORTHCOM is moving from Air Force to Navy command. Some public health preparedness and response research that they have funded focus on issues that DOD appears to be relearning every time an event happens. One project focuses on information flow, identification of gaps, and means to address these gaps. She pointed out that DOD is also looking at exercises done by communities. Academic, private, and public sectors have been involved and it has been a worthwhile experience. She welcomed any ideas for needs and locations to exercise.

Dr. Barbara Ellis asked for one last call for any public comments. No comments were offered from the public.

Dr. Sosin asked Chris Kosmos from DSLR to provide a brief update to the Board on recent efforts regarding the PHEP.

Chris Kosmos shared that one reason DSLR wanted to delay the new cooperative agreement is so that they would have the revisions to the target capabilities list (TCL). She noted that they are still a bit behind on the TCL, but DSLR is moving forward as a group regardless. The National Health Security Strategy (NHSS) has now been released. DSLR has been in discussions with subject matter experts to define what it means to be ready and what it means to achieve that capability. DSLR is in the process of developing an assessment tool for state and local health departments to identify gaps. It is inclusive of the capabilities and they have mapped that back to DSLR strategies as well. DSLR is on target for doing that work and for being inclusive with the NHSS. She noted that DSLR is making adjustments as they need to, looking for other information that might be coming out of ASPR. DSLR has also been working on a communication plan for how to socialize the cooperative agreement. DSLR has discussed the major components of the agreement with the preparedness directors and did receive positive feedback for the Change Management Board.

Dr. Sosin stated that he would like to reinforce the importance of communication and transparency. He pointed out that it was a major factor in our success in the response to H1N1. This Board is one of the few sanctioned forums to receive input and advice and he thanked all that are involved in participating and sharing information to make sure OPHPR has the best advice. He acknowledged that the breadth of awareness among the Board and the expertise of the Ex Officios are very important to OPHPR. Going forward, he stated that OPHPR appreciates hearing from your offices any feedback you can provide us on this meeting or other forums and that OPHPR looks forward to the next in-person meeting. Dr. Sosin solicited ideas and suggestions of things that would be helpful to the Board and also for reviews. He pointed out that OPHPR has had successful reviews by the BSC. He advised that the BSC will hear more about those at the next meeting, although acknowledging experience with program fatigue due to H1N1, Haiti, and other emergency responses. He pointed out the need to have a conversation to consider where additional reviews should be focused.

Dr. Barbara Ellis expressed thanks to Drs. Ellen MacKenzie and Jack Harrald for giving OPHPR their time today. She noted that OPHPR will try to convene the next in-person meeting in August and expressed her hope that new members would be on board by then.

Adjourn / Certification

With no further business raised or discussion posed, Dr. Barbara Ellis officially adjourned the BSC meeting.

I hereby certify that to the best of my knowledge, the foregoing minutes of the April 26, 2010 OPHPR BSC meeting are accurate and complete:

07/21/2010
Date

-s-

Barbara A. Ellis, Ph.D.
Designated Federal Official

OPHPR BSC Membership Roster

Chair
Vacant

Executive Secretary
Barbara A. Ellis, Ph.D.
Acting Associate Director for Science
OPHPR - CDC
Atlanta, GA

Board Members
Sharona Hoffman, J.D., L.L.M
Professor of Law and Bioethics
Case Western Reserve University School of Law
Cleveland, OH
Term: 2/6/2008 – 9/30/2012

Ellen MacKenzie, Ph.D.
Professor and Chair
Department of Health Policy and Management Johns Hopkins University
Bloomberg School of Public Health
Baltimore, MD
Term: 2/6/2008 – 9/30/2011

John (Jack) Muckstadt, Ph.D.
Professor
School of Operations Research and
Industrial Engineering - Cornell University
Ithaca, NY
Term: 2/5/2008 – 9/30/2010

Louis Rowitz, Ph.D.
Director
Mid-America Regional Public Health Leadership Institute - University of Illinois at Chicago,
School of Public Health
Chicago, IL
Term: 2/18/2008 – 9/30/2012

Robert J. Ursano, M.D.
Chairman, Department of Psychiatry
Uniformed Services University of Health Sciences
Bethesda, MD
Term: 6/25/08 – 9/30/2012

Ex Officio Members
U.S. Department of Health and Human Services (HHS)
Mary Mazanec, M.D., J.D.
Deputy Assistant Secretary for Preparedness and Response, and Director, Office of Medicine, Science, and Public Health
Office of the Assistant Secretary for Preparedness and Response (ASPR)

U. S. Department of Health and Human Services
Washington, DC

U.S. Department of Homeland Security (DHS)
Terry A. Adirim, M.D., M.P.H.
Senior Medical Advisor - Office of Health Affairs
U.S. Department of Homeland Security
Washington, DC

U.S. Department of Defense (DoD)
Amy Kircher, M.P.H., Dr.PH.
Epidemiologist, Office of the Command Surgeon
NORAD – US Northern Command
Petersen AFB, CO

Liaison Representatives
Association of Public Health Laboratories (APHL)
Mary J. Gilchrist, Ph.D., D(ABMM)
Consultant, Public Health
Solon, IA

Association of Schools of Public Health (ASPH)
James W. Curran, M.D., M.P.H.
Dean, Rollins School of Public Health
Co-Director, Emory Center for AIDS Research
Emory University
Atlanta, GA

Association of State and Territorial Health Officials (ASTHO)
Damon T. Arnold, M.D., M.P.H.
Director, Illinois Department of Public Health
Chicago, IL

Council of State and Territorial Epidemiologists (CSTE)
Patricia Quinlisk, M.D., M.P.H.
Medical Director and State Epidemiologist
Iowa Department of Public Health
Des Moines, IA

National Association of County and City Health Officials (NACCHO)
Karen Smith, M.D., M.P.H.
Public Health Officer and Director of Public Health
Napa County Health and Human Services Agency Public Health Division
Napa, CA

National Indian Health Board (NIHB)
Stacy A. Bohlen, M.A.
Executive Director, NIHB
Washington, DC

Participant List

LAST NAME	FIRST NAME	AFFILIATION
Anason	Andrea	OPHPR
Austin	Lynn	OPHPR
Bashor	Mark	OPHPR
Benson	Maggie	HHS Office of Inspector General, Office of Evaluation and Inspections
Biasidecki	Laura	Association of Schools of Public Health
Brooks	Trevia	OPHPR
Brown	Tara	OPHPR
Davis	Xiaohong	OPHPR
Downie	Diane	OPHPR
Ellis	Barbara	OPHPR
Gadsden-Knowles	Kim	OPHPR
Galloway	Karen	OPHPR
Gorman	Sue	OPHPR
Horan	John	OPHPR
Howard	Joyce	OPHPR
Hume	Lynn	OPHPR
Jackson	Wilma	OPHPR
Jennings	Matthew	OPHPR
Jones	Terrance	OPHPR
King	Keesler	OPHPR
Kosmos	Chris	OPHPR
Kostus	Kristin	OPHPR
Lee	Grace	OPHPR
Lutz	Pam	OPHPR
McLees	Anita	OPHPR
McMichael	Janice	OPHPR
Mumford	Karen	OPHPR
O'Connor	Ralph	OPHPR
Ogbuawa	Ngozi	OPHPR
Ostrowski	Stephanie	OPHPR
Popiak	Jean	OPHPR
Qari	Shoukat	OPHPR
Robinson	Andrea	OPHPR
Rzeszotarski	Peter	OPHPR
Salter	Monique	OPHPR
Shindelar	Amelia	OPHPR
Shumock	Nick	OPHPR
Singleton	Christa	OPHPR

LAST NAME	FIRST NAME	AFFILIATION
Slifkin	Gideon	OPHPR
Sloop	Kira	ICS MACRO
Smith	Greg	OPHPR
Sosin	Dan	OPHPR
Stevens	Sheila	OPHPR
Tabladillo	Mark	OPHPR
Talbert	Todd	OPHPR
Theophilus	John	OPHPR
Thomas	Craig	OPHPR
Tierney	Linda	OPHPR
Twedt	Tru	OPHPR
Walker	Lisa	OPHPR
Wasil	Julie	OPHPR
Weyant	Rob	OPHPR
Wooster	Mark	OPHPR
Young	Andrea	OPHPR
Zaza	Stephanie	OPHPR

Acronyms

APHL	Association of Public Health Laboratories
ASPH	Association of Schools of Public Health
ASPR	Assistant Secretary for Preparedness and Response (HHS)
ASTHO	Association of State and Territorial Health Officials
BSC	Board of Scientific Counselors
BCU	Biosurveillance Coordination Unit (CDC)
CA	Cooperative Agreement
CDC	Centers for Disease Control and Prevention
CMB	Change Management Board
CSTE	Council of State and Territorial Epidemiologists
DEO	Division of Emergency Operations (OPHPR)
DFO	Designated Federal Official
DHS	U.S. Department of Homeland Security
DHHS	U.S. Department of Health and Human Services
DOD	U.S. Department of Defense
DSLR	Division of State and Local Readiness (OPHPR)
FACA	Federal Advisory Committee Act
FEMA	Federal Emergency Management Agency (DHS)
H1N1	Influenza virus (2009 H1N1 pandemic)
HHS	U.S. Department of Health and Human Services
HSPD	Homeland Security Presidential Directive
NACCHO	National Association of County and City Health Officials
NHSS	National Health Security Strategy
NIHB	National Indian Health Board
OMEB	Outcome Monitoring and Evaluation Branch (OPHPR)
OPHPR	Office of Public Health Preparedness and Response (CDC)
OSTLTS	Office of State, Tribal, Local and Territorial Support (CDC)
PAHPA	Pandemic and All Hazards Preparedness Act (PL 109-417)
PERRC	Preparedness and Emergency Response Research Centers
PHEP	Public Health Emergency Preparedness Cooperative Agreement
TCL	Target Capabilities List
USNORTHCOM	U.S. Northern Command